APPLICATION FOR USANAF RETIREMENT PLAN AND/OR GROUP INSURANCE PLANS

For use of this form, see AR 215-3; the proponent agency is ODCSPER.
Read Privacy Act Statement and instructions on reverse prior to completing this form.

PART I - APPLICATION FOR USANAF RETIREMENT PLAN

1. EMPLOYEE NAME (Last, first, MI,)
LAST NAME
FIRST NAME MI

2. SEX

3. STANDARD NAFI NO.

4. TRANSACTION CODE
Must Select One Code

5. COMPLETE MAILING ADDRESS (Include Street, Apt/Unit No., City, State or Country, and ZIP Code)
STREET APT/UNIT
CITY ST ZIP

6. SSN (9 Digits, No Dashes)

7. COMMENCE LWOP
END LWOP

8. DATE OF BIRTH
Day Month Year

9. REGULAR APPT. DATE
Day Month Year

10. SALARY SCHEDULE
PER ANNUM $

11. REGULARLY SCHEDULED HOURS
PER WEEK
HOURLY RATE $

12. MARRIED

13.a. TRANSFER DATE
Day Month Year

13.b. TERMINATION DATE
Day Month Year

14. DESIGNATION OF BENEFICIARY(IES) FOR USANAF RETIREMENT PLAN. If employee is married, beneficiary must be the legal spouse. If spouse is deceased, beneficiary must be dependent children under the age of 18, otherwise, the name(s) stated below will be my legal beneficiary(ies) in case of my death, unless changed at a later date. I revoke any and all beneficiary designation which I have previously made for retirement plan contributions. Include full name, complete mailing address, zip code and date of birth. If more than one beneficiary, designate primary or secondary. Attach additional paper if more space is needed. Sign and date all attachments.

Additional Beneficiary Designations Attached: No

SPOUSE	Spouse	STREET	CITY	ST	ZIP	DOB

15. RETIREMENT PLAN PARTICIPATION

PUT AN 'X' IN ONE BOX ONLY

☐ a. I elect to participate.

EFFECTIVE DATE (DAY MO YR)

☐ b. I elect not to participate. I understand that no retirement benefits will be available to me because of my NAF employment.

☐ c. I am a vested transfer employee from USANAF to APF (appropriated fund) and I elect to continue participation in the USANAF Retirement Plan, IAW Public Law 101-508; 104-106. (Must also complete and attach FORM RI 28-110 SF 830-1.)

EFFECTIVE DATE (DAY MO YR)

☐ d. I am a transfer employee from one Army NAFI to another. I elect to continue participation in the USANAF Retirement Plan.

☐ e. I elect to stop contributions. Contributions will remain on deposit until termination of employment.

16. PREVIOUS ENROLLMENT IN A NAFI RETIREMENT PLAN

I was previously employed by a NAFI as a regular full-time or regular part-time employee and I participated in the retirement plan under the following branch(es) of the armed services: (Complete all applicable areas.)

		FROM	THRU
☐	Air Force		
☐	AAFES		
☐	Marines		
☐	Navy		
☐	Navy Exchange		
☐	Coast Guard		
☐	None		

17. PREVIOUS ENROLLMENT IN USANAF RETIREMENT PLAN

a. I was previously enrolled in the USANAF Retirement Plan: NO

b. I received a refund of contributions from Army NAF.

DATE OF REFUND (DAY MO YR)

As a previous USANAF Retirement Plan participant, I am aware that I am eligible to redeposit prior contributions and interest within 2 years of my re-hire date at 3% compounded interest. I do not have to redeposit prior refunds in order to receive credited service actuarially reduced.

22. TYPED NAME, TITLE AND TELEPHONE NO. OF CPO

18. LEGAL SPOUSE DATA

a. SPOUSE'S NAME (Last, first, MI)
Spouse Last Name
Spouse First Name Sp M.I

b. SSN (9 Digits, No Dashes)

c. DATE OF BIRTH

d. ADDRESS IF DIFFERENT FROM EMPLOYEE

e. DATE OF MARRIAGE

I authorize deductions from my earnings for the USANAF Retirement Plan. If I am on a LWOP status, I do not have to make contributions to the USANAF Retirement Plan for up to 1 year.

19. EMPLOYEE SIGNATURE

20. DATE SIGNED

21. NAME, ADDRESS AND TELEPHONE NO. OF SERVICING CPO (Include ZIP Code)

23. SIGNATURE OF AUTHORIZING OFFICIAL

24. DATE SIGNED

DO NOT USE - FOR OFFICIAL USE ONLY

DATE RECEIVED	DATE PROCESSED	PROCESSED BY	TRANSACTION TYPE

PART II - APPLICATION FOR USANAF GROUP INSURANCE PLANS

1. EMPLOYEE NAME (Last, first, MI, maiden)
LAST NAME
FIRST NAME MI

2. SEX

3. STANDARD NAFI NO.

4. TRANSACTION CODE
Must Select One Code

5. COMPLETE MAILING ADDRESS (Include Street, Apt/Unit No., City, State or Country, and ZIP Code)
STREET APT/UNIT
CITY ST ZIP

6. SSN (9 Digits, No Dashes)

7. COMMENCE LWOP
END LWOP

8. DATE OF BIRTH
Day Month Year

9. REGULAR APPT. DATE
Day Month Year

10. SALARY SCHEDULE
PER ANNUM $

11. REGULARLY SCHEDULED HOURS
PER WEEK
HOURLY RATE $

12. MARRIED

13.a. TRANSFER DATE
Day Month Year

13.b. TERMINATION DATE
Day Month Year

14. DESIGNATION OF BENEFICIARY(IES) FOR GROUP LIFE INSURANCE COVERAGE. The names designated here will be my legal beneficiary(ies) in case of my death, unless changed at a later date. I revoke any and all beneficiary designation which I have previously made under this coverage. Include full name, relationship, complete mailing address, zip code and date of birth. If more than one beneficiary, designate primary or secondary. Attach additional paper if needed. Sign and date all attachments.
Additional Beneficiary Designations Attached: NO

LIFE BENEF1	Mother	STREET	CITY	STATE	ZIP	DOB

15. GROUP MEDICAL AND DENTAL INSURANCE ELECTION

COVERAGE ELECTION DATE			OPEN SEASON ELECTION
DAY	MONTH	YEAR	NO
Eff. 1/1/2000, election date is date employee signs form			

PUT AN 'X' IN THE BOXES THAT APPLY

- [ ] a. I do not want group medical and dental insurance.
- [ ] b. I request participation in the insurance plan stated here:

THIS ELECTION MAY ONLY BE CHOSEN WITHIN 31 DAYS OF HIRE OR ELIGIBLE STATUS OR DURING THE OPEN SEASON PERIOD.

- [ ] c. I request change from: / to plan:
- [ ] d. I am a transfer employee and I elect to continue participation in:
  MEDICAL PLAN
  TRANSFER DATE (DAY MO YR)
- [ ] e. I request cancellation of medical coverage.
  (I cannot select this option outside of the open season period or separation, if my premiums are being paid with pre-tax dollars. My premiums will be paid with pre-tax dollars, unless I elected NO at enrollment or open season.)
- [ ] f. I decline payment of medical premiums with pre-tax dollars.
  (see instructions on reverse side for explanation of this election)

16. GROUP LIFE INSURANCE ELECTION

COVERAGE ELECTION DATE			OPEN SEASON ELECTION
DAY	MONTH	YEAR	NO

PUT AN 'X' IN ONE BOX ONLY

- [ ] a. I do not want group life insurance.
- [ ] b. I request participation in one of the following plans:
- [ ] 1 TIMES BASIC SALARY ABOVE
- [ ] 2 TIMES BASIC SALARY ABOVE
- [ ] 1 TIMES BASIC SALARY PLUS OPTIONAL $ NONE
- [ ] 2 TIMES BASIC SALARY PLUS OPTIONAL $ NONE

BASIC INSURANCE CANNOT EXCEED $250,000.00. OPTIONAL INSURANCE MAY BE UP TO 2 TIMES THE AMOUNT OF BASIC INSURANCE, IN MULTIPLES OF $10,000.00 NOT TO EXCEED $500,000.00. (Opt. over $250K requires Evidence of Insurability.)

- [ ] c. I am a transfer employee and I elect to continue coverage in life plan.
  TRANSFER DATE (DAY MO YR)
- [ ] d. I request cancellation of life insurance coverage.

17. DEPENDENT DATA (Attach additional paper if more space is needed.)

CODES: S=SPOUSE; C=CHILD; DD=DISABLED DEPENDENT; SC=STEPCHILD LIVING WITH YOU

Last Name,	FI	Code	Social Security Number	Day	Month	Year

I authorize deductions from my earnings for the insurance elected. If I am on a LWOP status, my employer will pay my premiums NTE 1 year. I am responsible for paying LWOP premiums back to my employer as arranged with me by my employer.

18. EMPLOYEE SIGNATURE

19. DATE SIGNED

20. NAME, ADDRESS AND TELEPHONE NO. OF SERVICING CPO (Include *ZIP code)*

21. TYPED NAME, TITLE AND TELEPHONE NO. OF CPO

22. SIGNATURE OF AUTHORIZING OFFICIAL

23. DATE SIGNED

DO NOT USE - FOR OFFICIAL USE ONLY

DATE RECEIVED	DATE PROCESSED	PROCESSED BY	TRANSACTION TYPE

DATA REQUIRED BY THE PRIVACY ACT OF 1974	
AUTHORITY:	Internal Revenue Service Code, Section 401 (a).
PRINCIPAL PURPOSE(S):	To enroll USANAF employees in the retirement plan and to update their records once enrolled. All regular employees must elect or decline participation.
ROUTINE USES:	To establish and maintain records of eligible participating and former participating USANAF employees. To furnish verifying data to the commercial Insurance companies which actually pay claims. To prepare bills to NAF activities monthly to collect the employee and employer contributions.
DISCLOSURE:	Disclosure is voluntary. Failure to provide information will result in employee not being enrolled in the Group Retirement Plan.

INSTRUCTIONS FOR COMPLETING DA FORM 3473, PART I

(Also see Morale, Welfare, and Recreation Update 215-3, Chapter 15)

SEND COPIES TO: USANAF EMPLOYEE BENEFITS BRANCH, P.O. BOX 107, ARLINGTON, VA 22210-0107
AND YOUR SERVICING PAYROLL OFFICE.

ITEM

1. Enter Last Name (TAB), First Name (TAB), Middle Initial (TAB).

2. Select Sex from the drop down box (TAB)

3. Enter Standard NAFI Number (SNN) assigned in accordance with AR 215-1, Appendix G. (TAB)

4. Transaction code. Select Transaction Code from the drop down box. If 2 transactions codes are needed, use the second drop down box. (TAB)

   00 - No enrollment. (Complete DA 3473, Part I, for all new eligible employees who do not make an election.)

   01 - New enrollment. (Complete DA 3473, Part I, who make an election.)

   02 - Transferred employee. (Complete DA 3473, Part I, by both losing and gaining activities and put date in 13a.) Gaining NAFI and employee must show continuing participation in USANAF Retirement on this form.

   03 - Reinstatement/Reemployment. (Complete DA 3473, Part I, for all eligible rehires.)

   04 - Termination of employment; change from regular appointment to a nonqualifying appointment. (Attach DA Form 3715-R when applicable.) DO NOT USE THIS CODE FOR TRANSFERS OF EMPLOYMENT FROM ONE ARMY NAFI TO ANOTHER (SEE CODE 02).

   06 - Stop retirement contributions.

   11 - Change or correction of name and/or address.

   19 - Correction of social security number.

   21 - Employee in LWOP status, employee contributions will stop. LWOP NTE one year, employee continues to earn creditable service.

   23 - Change of retirement plan beneficiary. (If married, beneficiary must be spouse if married longer than 1 year.)

   24 - Cease participation in USANAF retirement plan. (Must wait 2 years before reenrolling.)

   25 - Re-enroll in USANAF retirement plan. (If participation is cancelled after this re-enrollment, employee may not participate again.)

5 through 8. Use the TAB key after each entry. Select appropriate dates from the drop down boxes.

9. Enter earliest date in eligible status. (TAB)

10. Enter annual salary. (TAB)

11. Enter number of hours regularly scheduled and hourly rate. (TAB)

12. Select Yes or No from the drop down box. (TAB)

13.a. Complete this field using the drop down box, only if employee is transferring to another Army NAFI. (TAB)

13.b. Select date from the drop down boxes. Complete when separating employment or converting from a regular position to a flexible position. (TAB)

14. Employee may elect more than one primary beneficiary. Proceeds will be divided amongst primary beneficiaries. If additional paper is attached to designate beneficiaries, employee must sign and date beneficiary designations, select "Yes" on the front of this form. (TAB)

15 and 17. Refer to administrative manual. Effective date is the date the employee elects the retirement plan. Deductions will begin the first day of the first full pay period on or after date of election. Must be completed by all new eligible employees.

18. Must be completed by employee if married or separated.

19 through 24. Employee signature date must be selected from the drop down box. Self explanatory.

INSTRUCTIONS FOR COMPLETING DA FORM 3473, PART II

(Also see Morale, Welfare, and Recreation Update 215-3, Chapter 15)

SEND COPIES TO: USANAF EMPLOYEE BENEFITS BRANCH, P.O. BOX 107, ARLINGTON, VA 22210-0107
AND YOUR SERVICING PAYROLL OFFICE.

ITEM

1. Enter Last Name (TAB), first Name (TAB), Middle Initial (TAB)

2. Select Sex from the drop down box (TAB)

3. Enter Standard NAFI Number (SNN) assigned in accordance with AR 215-1, Appendix G. (TAB)

4. Transaction code. Select Transaction Code from the drop down box. If 2 transaction codes are needed, use the second drop down box. (TAB)

00 - No enrollment. (Complete DA 3473, Part II, for all new eligible employees who do not make an election.)

01 - New enrollment. (Complete DA 3473, Part II for those who elect medical or life insurance coverage.

02 - Transferred employee. (Complete DA 3473, Part II, by both losing and gaining activities and put date in 13a.) Gaining NAFI and employee must show continuing participation in medical plans on this form. Employee may change from the NAF Medical Plan to an HMO, if the HMO was not offered at the losing NAFI, otherwise must wait until open season.

03 - Reinstatement/Reemployment. (Complete DA 3473, Part II, for all eligible rehires.)

04 - Termination of employment; change from regular appointment to a non-qualifying appointment. (Attach DA Form 3715-R when *applicable.) DO NOT USE THIS CODE FOR TRANSFERS OF EMPLOYMENT FROM ONE ARMY NAFI TO ANOTHER (SEE CODE 02).*

05 - Request Medical and/or Life Insurance; add dependent coverage (eligible within 31 days of acquiring first dependent or date of *marriage); delete dependent coverage; cancellation of medical insurance and/or life insurance; open enrollment changes (adding or deleting coverage); change in amount of life insurance.*

11 - Change or correction of name, address, etc.

19 - Correction of social security number.

20 - Employee in LWOP status, employer pays employee and employer premiums, NTE 1 Yr.

21 - Employee in LWOP status, employee and employer contributions will stop. Insurance coverage suspended for duration of LWOP *NTE one year. (See AR 215-5, 8-16.)*

22 - Change of life insurance beneficiary. (Use DA Form 3473, Part I, to change retirement beneficiary.)

5 through 8. Self explanatory. Use the TAB key after each entry. Select appropriate dates from the drop down boxes.

9. Enter earliest date in eligible status. (TAB)

10. Enter annual salary. (TAB)

11. Enter number of hours regularly scheduled and hourly rate. (TAB)

12. Select Yes or No from the drop down box. (TAB)

13.a. Complete this field using the drop down box, only if employee is transferring to another Army NAFI.

13.b. Select date from the drop down boxes. Complete when separating employment or converting from a regular position to a flexible position. (TAB).

14. Employee may elect more than one primary beneficiary. Proceeds will be divided amongst primary beneficiaries. If additional paper is attached to designate beneficiaries, employee must sign and date beneficiary designations on separate form. Select "Yes" on front of form.

15 and 16. Effective date for the DoD NAF HBP will be the date the form is signed by the employee within 31 days of hire. Effective date of Life Insurance and HMO coverage will be the first day of the first full pay period, on or after coverage election date (except for open season elections). Must be completed by all new eligible employees. Refer to www.NAFbenefits.com. Employee should check leave and earnings statement for correct coverage deductions. Basic Life Insurance cannot exceed $250K. Optional life insurance cannot exceed $500K. Evidence of Insurability required on more than $250K optional ins. (Life coverage may be elected at anytime, provided the employee can prove evidence of insurability. Eff 1 Jul 00, all employees pay medical premiums with pre-tax dollars, unless they elect otherwise.)

17 through 23. All fields required to be completed. Self explanatory.